

Review Article

Clinical Emotional Friction in Nursing Communication: An Interpretive Framework of Patient Misalignment and Interaction ResponseDipak Paul¹, Howard Moskowitz^{1,2*}, Sharon Wingert², David Stevens³, Daniel Moskowitz¹, Brown Fitterman⁴¹Mind Genomics Associates Inc., White Plains, New York, USA²Tactical Data Group, Stafford, Virginia, USA³Advanced Learning Strategies, Silver Lake, New Hampshire, USA⁴TikunTek, Atlanta, Georgia, USA**Abstract**

Clinical communication in nursing care involves continuous micro-level interactions through which patients interpret tone, timing, pacing, emotional engagement, and presence. Small mismatches between patient expectations and communication behavior may create clinical emotional friction, an interpretive gap that can influence emotional comfort, trust, and willingness to engage in care. Importantly, the same communication behavior may be interpreted differently across patients depending on their communication priorities and emotional expectations. This paper presents a Mind Genomics-inspired conceptual framework for understanding how patients interpret communication misalignment during nursing interactions. The framework organizes interpretive variation into four conceptual mindsets: Emotion-Driven Friction Interpreters, Clarity-Driven Friction Interpreters, Personalization-Driven Friction Interpreters, and Autonomy-Driven Friction Interpreters. Eight representative interaction issues within nursing communication are examined across these interpretive orientations to illustrate how the same interaction may generate different emotional meanings for different patients. The framework suggests that communication breakdown may emerge not only from communication behavior itself, but from differences in how that behavior is interpreted. In addition, the paper outlines conceptual opportunities for reducing emotional friction through adaptive, patient-centered communication approaches. Overall, the framework provides a structured perspective for understanding interpretive variability in nursing communication and highlights the importance of communication alignment and interpretive sensitivity within clinical care.

Keywords: Clinical emotional friction; Nursing communication; Patient interpretation; Communication misalignment; Patient-centered care; Interpretive mindsets; Emotional alignment

Introduction

Clinical communication is experienced by patients not as isolated exchanges, but as a continuous flow of micro-level interactions. Subtle variations in tone, timing, pacing, or presence are rapidly perceived and interpreted. Even small mismatches—such as delayed responses, emotionally flat tone, or misaligned pacing—can create a sense of disconnect between what the patient expects and what is delivered.

This disconnect can be understood as clinical emotional friction, defined as the gap between a patient's implicit emotional expectation and the communication behavior encountered during care. Research in clinical communication demonstrates that patients rely on both verbal and nonverbal cues to form judgments about empathy, attentiveness, and trust [1]. From a neurophysiological perspective, patients may rapidly interpret interpersonal cues such as tone, timing, and emotional expression during clinical interactions, influencing perceptions of safety, responsiveness, and emotional connection [2]. Importantly, emotional friction is not experienced uniformly. The same interaction may be interpreted differently across patients. Evidence suggests that individuals vary in how they interpret

communication signals and construct meaning from clinical encounters [3,4]. Some patients prioritize emotional reassurance, others clarity and structure, some seek individualized attention, and others value autonomy and minimal intrusion.

These differences indicate that communication breakdown is not solely determined by what is said, but by how it is interpreted. The present framework aims to organize this variation in interpretation into a structured form that can support understanding and practical application in clinical settings.

Canonical Design

This paper adopts a Mind Genomics-inspired conceptual approach to organize variation in how patients interpret communication during nursing interactions. Rather than relying on experimental coefficients or statistical estimation, the objective is to represent interpretive differences in a structured and clinically meaningful way.

The framework begins by identifying a set of representative interaction points within routine nursing communication where alignment or mis-

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alignment may occur. These include tone, timing, pacing, touch, emotional engagement, environmental context, presence, and closure. These elements reflect commonly discussed dimensions of verbal and nonverbal communication that influence how patients perceive care interactions [1,5]. They are not presented as an exhaustive or definitive list, but as representative interaction points through which patients form judgments about care.

Building on these interaction points, the framework considers how patients actively interpret communication rather than passively receiving it. Interpretive research in healthcare suggests that patients construct meaning based on prior expectations, emotional state, and contextual cues [6]. This implies that the same interaction may be understood differently across individuals, even when the observable behavior remains unchanged.

To organize this variation, the framework introduces a set of interpretive orientations, referred to here as mindsets. These mindsets were informed by recurring priorities described in patient-centered communication literature, including the need for emotional reassurance, clarity and predictability, individualized attention, and autonomy [3,4,7]. Rather than representing fixed patient types, these mindsets reflect dominant evaluative tendencies that shape how communication is interpreted.

The construction of the framework proceeds by systematically aligning each identified interaction point with each interpretive mindset. In this process, the same communication condition is considered through different evaluative priorities. For instance, a mismatch in tone may be interpreted as emotional distance by a patient seeking warmth, as lack of clarity by a patient seeking structure, as impersonal communication by a patient seeking individual attention, or as intrusion by a patient valuing autonomy. By applying this logic consistently across all interaction points, a structured pattern of interpretive variation is generated.

The resulting configuration is presented in the form of a Mindset Table. Each cell in the table reflects a conceptually derived interpretation that emerges from the interaction between a communication condition and a specific interpretive priority. The table is therefore not based on empirical measurement, but on systematic conceptual mapping grounded in established principles of communication and patient experience.

Mindset Table: How Patients Interpret Clinical Emotional Friction

Issue	Mindset A: Emotion-Driven Friction Interpreters	Mindset B: Clarity-Driven Friction Interpreters	Mindset C: Personalization-Driven Friction Interpreters	Mindset D: Autonomy-Driven Friction Interpreters
1. Tone Mismatch	They feel friction when tone lacks warmth. Cold tone increases anxiety. They judge alignment by emotional presence.	They feel friction when tone lacks clarity. Emotional tone feels distracting. They judge alignment by structure.	They feel friction when tone feels generic. They want tone tailored to them. They judge alignment by attunement.	They feel friction when tone is too emotional. Warmth feels intrusive. They judge alignment by restraint.
2. Timing Errors	They feel friction when reassurance comes too late. Delayed timing feels neglectful. They judge alignment by emotional urgency.	They feel friction when explanations are delayed. Timing inconsistency feels unsafe. They judge alignment by predictability.	They feel friction when timing does not match their emotional rhythm. Generic timing feels indifferent. They judge alignment by personalization.	They feel friction when timing is too frequent. Early or unsolicited timing feels intrusive. They judge alignment by independence.
3. Misaligned Touch (When Appropriate)	They feel friction when supportive touch is absent. Lack of warmth feels distancing. They judge alignment by empathy.	They feel friction when touch is used emotionally rather than clinically. Emotional touch feels unprofessional. They judge alignment by boundaries.	They feel friction when touch feels mechanical. They want touch that reflects personal understanding. They judge alignment by attunement.	They feel friction when touch occurs at all. Touch feels intrusive. They judge alignment by autonomy.

This approach allows the framework to illustrate how differences in interpretation may arise across patients in response to the same clinical interaction, without assuming uniformity in patient perception.

Introducing the Topic and the Mindsets

Clinical emotional friction is not determined solely by what occurs in the interaction, but by how that interaction is interpreted. Patients differ in the aspects of communication they prioritize and in the criteria they use to evaluate whether an interaction feels appropriate, supportive, or intrusive.

Within this framework, four interpretive mindsets are proposed to represent these differences. These include Emotion-Driven Friction Interpreters who evaluate communication primarily through emotional tone and empathy; Clarity-Driven Friction Interpreters, who prioritize structure, predictability, and informational clarity; Personalization-Driven Friction Interpreters, who assess communication based on individual relevance and attunement; and Autonomy-Driven Friction Interpreters who focus on independence, control, and the absence of unnecessary intrusion.

These mindsets reflect underlying psychological priorities rather than rigid categories. They provide a structured way to understand how different patients may assign meaning to the same communication behavior. Each mindset emphasizes a distinct evaluative dimension, and this emphasis shapes how alignment or misalignment is perceived within clinical interactions.

Mindset Table Introduction

The table below presents eight interaction issues in nursing communication and illustrates how each of the four interpretive mindsets may respond to these conditions. Each issue represents a point at which patients evaluate communication, and each cell reflects a conceptually derived interpretation based on the alignment between the interaction condition and the underlying priority of the mindset.

By presenting these variations in a structured format, the table demonstrates how the same communication event can generate different perceptions depending on the interpretive orientation of the patient. This structured representation allows for a clearer understanding of how emotional friction may arise, not only from communication behavior itself, but from differences in how that behavior is interpreted.

4. Pacing Mismatch	They feel friction when care is rushed. Fast pacing feels unsafe. They judge alignment by calmness.	They feel friction when pacing is slow or inconsistent. Slow pacing feels inefficient. They judge alignment by clarity.	They feel friction when pacing does not match their processing speed. Generic pacing feels indifferent. They judge alignment by resonance.	They feel friction when pacing is controlled by staff. They want to set the pace. They judge alignment by freedom.
5. Emotional Over or Under Engagement	They feel friction when emotional support is missing. Coldness feels rejecting. They judge alignment by empathy.	They feel friction when emotional engagement is too early. Emotion before facts feels destabilizing. They judge alignment by order.	They feel friction when emotional engagement feels generic. They want personalized emotional pacing. They judge alignment by attunement.	They feel friction when emotional engagement is unsolicited. Emotional probing feels intrusive. They judge alignment by restraint.
6. Environmental Misalignment	They feel friction in cold or harsh environments. Emotional tone matters. They judge alignment by comfort.	They feel friction in disorganized environments. Ambiguity feels unsafe. They judge alignment by structure.	They feel friction in generic environments. They want personal resonance. They judge alignment by meaning.	They feel friction in over designed environments. They want simplicity. They judge alignment by freedom.
7. Presence Misalignment	They feel friction when the nurse is absent too long. Absence feels like abandonment. They judge alignment by continuity.	They feel friction when presence is unpredictable. Irregular presence feels chaotic. They judge alignment by order.	They feel friction when presence feels generic. They want presence tailored to them. They judge alignment by recognition.	They feel friction when presence is too frequent. Frequent contact feels intrusive. They judge alignment by independence.
8. Closure Misalignment	They feel friction when closure lacks warmth. Cold endings overshadow care. They judge alignment by emotional tone.	They feel friction when closure lacks structure. Emotional farewells feel unnecessary. They judge alignment by clarity.	They feel friction when closure feels generic. They want personalized endings. They judge alignment by recognition.	They feel friction when closure is emotional. They prefer minimal transition. They judge alignment by autonomy.

Conceptual Opportunities for Reducing Clinical Emotional Friction

The Mindset Table suggests that emotional friction emerges not only from communication behaviors themselves, but from differences in how those behaviors are interpreted across patients. Variability in emotional priorities, communication expectations, and tolerance for interaction may shape whether a clinical encounter is experienced as supportive, unclear, impersonal, or intrusive.

Viewed from this perspective, reducing emotional friction may require greater attention to interpretive differences during nursing communication. The following opportunities are presented as conceptually derived directions that may help improve communication alignment, reduce friction-related distress, and support more adaptive patient-centered care practices.

Each opportunity includes four proposed actions.

Opportunity 1: Interpretive Friction Awareness in Nursing Communication

1. Train nurses to recognize interaction patterns associated with emotional friction.
2. Use scenario-based exercises to improve sensitivity to interpretive differences.
3. Teach adaptive adjustment of tone, timing, pacing, and emotional presence.
4. Reinforce communication consistency across clinical settings and shifts.

Opportunity 2: Communication-Aligned Clinical Environments

1. Design clinical spaces that reduce communication-related discomfort.

2. Use environmental cues to support clarity, calmness, and emotional safety.
3. Evaluate environments across different interpretive mindsets.
4. Refine environmental features based on patient experience patterns.

Opportunity 3: Personalized Emotional Alignment Strategies

1. Tailor communication approaches to individual interpretive priorities.
2. Adapt tone, pacing, and engagement style according to patient response.
3. Train nurses to recognize signals of personalization mismatch.
4. Evaluate whether personalization reduces perceived friction.

Opportunity 4: Autonomy-Sensitive Interaction Systems

1. Develop interaction systems that preserve patient autonomy and control.
2. Reduce unnecessary emotional or procedural intrusion.
3. Offer flexible levels of communication engagement when appropriate.
4. Assess patient satisfaction related to autonomy and interaction intensity.

Opportunity 5: Emotional Friction Pattern Evaluation

1. Evaluate friction-related experiences across patient care touchpoints.
2. Use patient feedback to identify communication misalignment patterns.
3. Assess interaction quality across emotional, structural, personalized, and autonomy-related dimensions.
4. Use findings to improve communication training and care design.

Opportunity 6: Anticipatory Emotional Friction Management

1. Identify situations where emotional friction is likely to emerge.
2. Develop early intervention approaches before friction escalates.
3. Use supportive systems to strengthen communication alignment cues.
4. Prepare nursing staff for high-impact emotional interaction moments.

Discussion

Conceptual approaches to clinical communication have increasingly emphasized that patients respond not only to the informational content of healthcare interactions, but also to subtle relational and emotional cues embedded within communication. Research suggests that tone, responsiveness, timing, and nonverbal behavior influence how patients perceive empathy, attentiveness, trust, and emotional safety during care encounters [1,5]. Building on this broader understanding, the present framework focuses specifically on the emergence of clinical emotional friction when communication behaviors are experienced as misaligned with patient expectations and interaction priorities.

Within this framework, emotional friction is understood as fundamentally interpretive in nature. Although communication behaviors such as pacing, emotional engagement, tone, or presence may be observable during nursing interactions, their meaning is not fixed or universally experienced in the same way. Instead, patients actively interpret these behaviors according to their emotional expectations, contextual understanding, preferred interaction style, and perceived sense of control. This perspective is consistent with interpretive approaches in healthcare research suggesting that individuals construct meaning from relational and situational aspects of care encounters rather than responding uniformly to communication behavior itself [6].

The framework further suggests that communication breakdown in clinical settings may not always reflect objectively ineffective communication. In many situations, emotional friction may arise because a communication style that aligns with one interpretive orientation conflicts with another. For example, emotionally expressive communication may provide reassurance for Emotion-Driven Friction Interpreters while being experienced as intrusive or overstimulating by Autonomy-Driven Friction Interpreters. Similarly, highly structured explanations may reduce uncertainty for Clarity-Driven Friction Interpreters but may appear emotionally distant to patients seeking personalization or emotional resonance. These variations reinforce prior communication research demonstrating that patient experience is shaped not only by what clinicians communicate, but also by how communication is perceived and interpreted [1,4].

The four interpretive mindsets proposed in this framework are intended to organize recurring patterns through which emotional friction may emerge during nursing interactions. They are not presented as rigid or mutually exclusive patient categories. Rather, the mindsets represent dominant evaluative tendencies that may influence how communication behaviors are interpreted under particular clinical circumstances. Individual patients may demonstrate overlap across orientations, and interpretive priorities may shift depending on emotional state, illness severity, prior healthcare experiences, cultural expectations, or situational stressors.

Importantly, the present framework differs from communication models that focus primarily on emotional support, reassurance, or expressive openness alone. Instead, the model specifically examines mechanisms through which communication misalignment may contribute to discomfort, resistance, disengagement, or perceived emotional distance during otherwise routine clinical interactions. In this sense, the framework contributes a complementary perspective by organizing communication

breakdown dynamics into a structured interpretive model.

From a practical perspective, the framework suggests that improving nursing communication may require greater awareness of interpretive variability across patients. Strategies aimed exclusively at increasing emotional warmth, engagement, or informational clarity may not uniformly improve patient experience unless communication approaches are adapted to the patient's interpretive priorities. The opportunities proposed in this paper therefore emphasize flexibility, personalization, communication alignment, emotional sensitivity, and respect for patient autonomy rather than reliance on a single standardized interaction style. This perspective is consistent with patient-centered care literature emphasizing individualized communication and relational responsiveness within healthcare settings [3,7].

As a conceptual framework, the present model is intended to illustrate plausible patterns of interpretive variation within nursing communication rather than establish fixed or predictive patient classifications. The proposed mindsets and interaction interpretations were developed through structured conceptual mapping grounded in communication literature and interpretive reasoning rather than direct observational or experimental measurement. Consequently, the framework should be understood as an interpretive organizational model rather than an empirically validated taxonomy of patient behavior.

In addition, the framework focuses specifically on communication-related emotional friction within nursing interactions and does not attempt to address all broader contributors to patient distress. Emotional discomfort in healthcare settings may also be influenced by institutional pressures, workload demands, prior trauma, cultural communication norms, healthcare accessibility, and organizational conditions that extend beyond the scope of the present model. Future empirical research may help evaluate, refine, or expand these interpretive patterns across different clinical environments and patient populations.

Conclusion

Clinical emotional friction represents an important interpretive dimension of patient experience within nursing care. The present framework suggests that communication breakdown may emerge not only from communication behavior itself, but from differences in how patients interpret tone, timing, pacing, emotional engagement, and presence during clinical interactions.

By organizing these interpretive differences into four conceptual mindsets, the framework provides a structured perspective for understanding variability in patient responses to nursing communication. Although conceptual in nature, the model highlights the importance of communication alignment, interpretive sensitivity, and adaptive interaction strategies within patient-centered care.

The Role of AI in This Paper

Artificial Intelligence (AI) supported the development of this conceptual framework by helping organize, compare, and refine different communication and interpretation patterns discussed in the paper. AI-assisted reasoning was used to explore how the same nursing interaction might be interpreted differently depending on patient expectations, emotional priorities, and communication preferences.

AI may also support future nursing communication research by helping identify communication mismatch patterns, simulate interaction scenarios for training, and improve adaptive communication strategies within clinical care settings.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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